Open Enrollment

2004 Maricopa County Employee Insurance Benefit Plan

Saturday, October 11 through Monday, November 3, 2003

What's New for 2004

TO ENROLL ONLINE
http://ebc.maricopa.gov
https://www.maricopa.gov/openenrollment

Maricopa County

WELCOME TO 2004 BENEFITS OPEN ENROLLMENT

Despite significant increases in health care costs, Maricopa County is pleased to offer a very competitive benefits program to benefit-eligible employees and their families. This program enhances and strengthens your benefit choices while delivering a quality program. To accomplish this, we continue to introduce cost-sharing of healthcare expenses to employees that encourages using the most appropriate place of service when seeking medical care and choosing the most cost-effective prescription drugs. This is likely to be the last year that the County will be able to absorb such an increase in health care costs. In Fiscal Year 2004 Maricopa County has increased base pay by 3.9 percent, increased ASRS retirement contributions by 3.2 percent and will absorb approximately $10,500,000 in health care cost increases in order to prevent employee pay from eroding.

HOW TO GET STARTED

What's New for 2004 is your guide to accessing important enrollment information, learning about 2004 benefit changes and finding out how to complete your benefits enrollment for calendar year 2004. Many words or phrases found in this guide are fully described in the *Glossary of Managed Care Terms* section on page 19.

You must complete Open Enrollment for 2004, by completing a benefits enrollment (either online or using an enrollment form), regardless of whether you are making any changes to your benefit elections. You must also enroll in Mariflex flexible spending account(s), either online or on a Mariflex enrollment form, if you want to participate in 2004.

Open Enrollment for the 2004 Benefit Plan Year begins on Saturday, October 11th and ends at 5:00 PM on November 3rd, 2003.

The Benefit Plan Year begins on January 1, 2004 and ends on December 31, 2004. All changes made during open enrollment are effective January 1, 2004.

To complete your open enrollment online, go to one of the following Open Enrollment web sites beginning at 8:00 AM, Saturday, October 11 through 5:00 PM, Monday, November 3, 2003.

INTERNET: **https://www.maricopa.gov/openenrollment**

- PLEASE NOTE the "**s**" in **https**. This indicates you are accessing a secured web site. This site requires the password **PFU2RNG4A**, and it must be typed in CAPITAL LETTERS exactly as shown.

INTRANET: **http://ebc.maricopa.gov/openenrollment**

Your computer must have Internet Explorer version 5.5 SP2 installed, cookies must be enabled, and JavaScript must be enabled in order to access the online Open Enrollment system.

Open Enrollment online instructions can be found on page 14 of this guide.

For help in accessing the Online Open Enrollment system or web site, or to answer your questions about the minimum system requirements, call the eGov Help Desk at 602-506-4357, Monday – Friday, 6:30 AM – 5:00 PM.

You can logon to the Open Enrollment System using either your Social Security Number or your Employee Identification Number. Your Employee ID number is a 9-digit number that can be found on your paycheck stub. It begins with 81.

It is suggested you do not wait until the last day to complete your open enrollment elections in the event you encounter system-related problems. **Your open enrollment and Mariflex flexible spending account forms, if applicable, must be received by the Benefits Office no later than 5:00 PM, Monday, November 3, 2003.** Late enrollments will not be accepted due to IRS regulations.

If you do not have access to a computer and are completing your open enrollment on a paper enrollment form, **the form must be received by the Benefits Office no later than Monday, November 3 at 5:00 PM**. Forms are available at the Paper Depot locations listed on page 15.

YOUR ENROLLMENT PROCESS CHECKLIST

- ❑ **Review** all of your current benefit elections, your Mariflex flexible spending account election(s), your dependents names and birth dates, and your life insurance beneficiary information online (see online addresses above) to determine if changes need to be made. If you do not have access to a computer, you may call the Benefits Office at 602-506-1010 to review your current elections. Please note that there is a change in policy for designating your primary beneficiary for life insurance. If you are married, you must designate at least 50 percent of your life insurance to your spouse. If you want to designate more than 50 percent of your life insurance to someone other than your spouse, your spouse must sign and have notarized a beneficiary designation form. See the changes to life insurance on page 5.

- Carefully **read** the information in this guide. Some of the CIGNA products have made changes to the cost for specific benefits, and some benefit premium rates have changed. The Short-Term Disability Plan has several plan design changes. **Premium deductions for all benefits, except Mariflex flexible spending accounts will be made from the first two pay checks of the month – 24 pay checks per year instead of 26.**
- **Make your election decisions** carefully as they cannot be changed for Plan Year 2004, except as described below.

  You should not make your medical or dental election solely on the basis of a healthcare provider's participation with the vendor's network because physicians and dentists may stop participating during the Plan Year. If a specific physician or dentist is very important to you to continue to provide your health or dental care, you may want to consider selecting a product with Out-of-Network benefits such as Point of Service (POS) or Preferred Provider Organization (PPO). Such products with Out-of-Network benefits allow you the option to continue to see providers if they stop participating with the vendor's network, at higher out-of-pocket costs to you.

  Additionally, you should not make your medical election solely on the basis of which medications are on the approved drug list because medications may change their coverage status during the Plan year. For example, medications may change from preferred brand name level to a generic or non-preferred brand name level or may be removed from the approved list.
- **Make or confirm your elections online or via paper.**

  Make sure to fully complete the enrollment process online by going to the last screen and submitting your enrollment. This must be done even if you are not making changes. Simply follow the step-by-step directions in the *Open Enrollment Online Instructions* section later in the guide.

  Your pre-taxed benefit elections will not be able to be changed for the entire 2004 Plan (calendar) year, unless you have a qualified status change such as marriage, divorce, qualified medical child support order, birth or placement to adopt a child, death of a spouse or child, termination or commencement of your spouse's or dependent's employment, a change in you or your spouse's employment status (full time to part time or visa versa), unpaid leave of absence for you or your spouse, or a significant change in health or dental coverage because of your spouse's or dependent's employment. Qualified status changes must be made within 31 days of the date of the event, must be verified, and must be consistent with the event. Please note that changes such as a physician's continued participation in the provider network, increased drug costs or availability, or a mistake or dissatisfaction with your Plan choice are not considered a qualified status change.
- **Print your confirmation sheet** from the online Open Enrollment system or keep copies of all paper forms you submit to the Benefits Office. Enrollment forms can be faxed to the Benefits Office at 602-506-2354. You should keep a copy of your fax confirmation sheet in the event your fax is not received by the Benefits Office.
- **Watch for your new ID card in the mail. All new and existing CIGNA participants and all new HealthSelect and Walgreens Health Initiatives participants will be mailed a new ID card shortly before the end of 2003. Destroy your old ID card upon receipt of your new card.**

BENEFIT QUESTIONS

If you have questions about your benefits, the benefit changes for 2004, or the enrollment process, call 602-506-1010, press option 1, then option 1 again, and finally, option 4 or send an email to BenefitsService@mail.maricopa.gov. Benefit representatives are available from 8:00 AM to 5:00 PM, Monday through Friday to assist you.

TECHNICAL SUPPORT QUESTIONS

If you are having technical difficulties using the online open enrollment system call the eGov Help Desk at 602-506-HELP (4357), Monday – Friday, 6:30 AM – 5:00 PM.

WHAT'S NEW FOR 2004 BENEFITS

WHERE TO ACCESS BENEFITS INFORMATION

To review detailed Open Enrollment Plan Documents, including provider directories, go to:

- INTERNET: http://www.maricopa.gov/benefits
- INTRANET: http://ebc.maricopa.gov/hr/benefits

Or, visit one of the Paper Depots. See page 15 of this guide for the Paper Depot locations.

Or, vendor web site addresses can be found on the last page of this guide.

HEALTHSELECT MEDICAL PLAN

There are no changes to the HealthSelect benefits in 2004. To review a summary of HealthSelect benefits, turn to page 8. To review the complete Plan Document, refer to the *Where to Access Benefits Information* section above.

CIGNA HEALTH MAINTENANCE ORGANIZATION (HMO)

There are no changes to the CIGNA HMO benefits in 2004. To review a summary of CIGNA HMO benefits, see page 8. To review the complete Plan Document, refer to the *Where to Access Benefits Information* section above.

CIGNA POINT OF SERVICE (POS)

There are several changes to the CIGNA POS benefits in 2004. These changes include:

IN-NETWORK

Inpatient Hospital Copayment

- $100/day, $300 maximum per admission (It was $100 per admission. **Please Note:** The inpatient hospital copay will no longer be reimbursed by Maricopa County for services received after December 31, 2003. All claims for services prior to 2004 must be submitted to the Benefits Office no later than 6 months from the date of service to be eligible for reimbursement.)

Outpatient Surgery Copayment

- $100 (It was $50.)

Out of Pocket Maximum

- $900 Individual (It was $1000.)
- $1800 Family (It was $2000.)

Chiropractic Care

- $15 copayment (It was $10.)

Physical, Speech, and Occupational Therapy

- $15 copayment (It was $10.)

The CIGNA POS network now includes the Tucson service area. Services may now be received throughout the entire State of Arizona.

OUT-OF-NETWORK

There are no changes to the made to CIGNA POS Out-of-Network benefits in 2004.

To review a summary of CIGNA POS benefits, turn to page 9. To review the complete Plan Document, refer to the *Where to Access Benefits Information* section above.

CIGNA PREFERRED PROVIDER ORGANIZATION (PPO)

There are changes to the CIGNA PPO benefit in 2004. These changes include:

Primary/Preventive Care Coinsurance

- 20% Coinsurance after annual deductible (It was a $20 copay.)

Specialist Care Coinsurance

- 20% Coinsurance after annual deductible (It was a $30 copay.)

Maternity Care Office Visit Coinsurance

- 20% Coinsurance after annual deductible for the first visit, then it's covered 100%. (It was a $30 copay for the first visit.)

Physical, Speech, and Occupational Therapy Coinsurance

- 20% Coinsurance after annual deductible (It was a $20 copay.)

Chiropractic Care Coinsurance

- 20% Coinsurance after annual deductible (It was a $20 copay.)

To review a summary of CIGNA PPO benefits, turn to page 10. To review the complete Plan Document, refer to the *Where to Access Benefits Information* section above.

PRESCRIPTION BENEFITS (FOR ALL CIGNA PLANS)

There is a value-added change to the CIGNA Prescription Benefits in 2004. This change is:

- Medications that are currently excluded from prescription coverage, such as fertility or cosmetic medications, will be available at Maricopa County's discounted rate through Walgreens Health Initiatives (WHI) beginning January 1, 2004.

To review a summary of Walgreens Health Initiatives benefits turn to page 11. To review the complete Plan Document, refer to the *Where to Access Benefits Information* section above.

SHORT-TERM DISABILITY

There are several changes to the Short-Term Disability benefits in 2004. These change include:

- Reinstating the 40 percent benefit option.
- Increasing the elimination period to 21 consecutive days. (It was 14 days.)
- Changing the return-to-work incentive to 80 percent. (It was 100 percent.)

- Locking in the Open Enrollment benefit election coverage level for the entire benefit plan year (January 1 through December 31) regardless of a qualified status change. Enrollment, in or cancellation of Short-Term Disability coverage and changes in coverage levels will not be allowed until the next Open Enrollment cycle.
- Calculating the benefit amount and premium on your base salary, regardless of any special work assignments.
- Adding case management services for behavioral health disabilities.

To review the complete Plan Document, refer to the *Where to Access Benefits Information* section above.

VISION

A separate vision plan for employees who qualify for the Medical Waiver is being offered in 2004. The benefits are the same as the AVESIS plan described in the *2003 Know Your Benefits* guide, however the rates are paid in total by you. See page 17 of this guide for the rates. If you choose to enroll in this separate vision benefit, you must complete a vision enrollment form.

Vision enrollment forms and the *2003 Know Your Benefits* guide can be found by referring to the *Where to Access Benefits Information* section above.

Please note that employees who are covered under CIGNA or HealthSelect continue to have their vision benefit included in the cost of their medical insurance. No benefit changes have been made and no action is required for CIGNA or HealthSelect members.

EMPLOYER'S DENTAL SERVICE (EDS)

ORTHODONTIC SERVICES

A new orthodontic benefit will be available in 2004 by EDS. This benefit is a 25 percent discount **on all orthodontic services** provided by EDS orthodontists. When using this discount, the 24-month treatment limitation is eliminated. Metal banding, invisible braces, and Invisalign braces are covered. Coverage has been enhanced for appliances , such as expanders, reverse headgear, Herbst, Pendulum, Nance, Tongue Crib, Jaspers, Sagittal, and Schwartz. Prices on which the discount is calculated may vary by orthodontist. See the *Dental Plan* section below for more information.

MEDICAL WAIVER

The amount of the medical waiver **increases from $75 to $100 per month** in 2004. It will be paid in 24 payments. If you are not a current health plan participant and have other group health insurance coverage, you may wish to waive your group health coverage offered by Maricopa County. To waive your coverage, you must complete open enrollment either online or using a paper enrollment form and submit proof of your group health coverage under another group health insurance coverage to the Benefits Office. Maricopa County will reimburse you $100 per month if you waive your coverage, and you work at least 60 hours per pay period.

Arizona Health Care Cost Containment System (AHCCCS) coverage does not qualify as group health insurance coverage and does not qualify you to waive your group medical benefits or to be eligible for the waiver payment.

INPATIENT HOSPITALIZATION REIMBURSEMENT

Maricopa County will no longer reimburse the hospital copayment for the CIGNA POS plan. All claims for services prior to 2004 must be submitted to the Benefits Office no later than 6 months from the date of service to be eligible for reimbursement.

LIFE INSURANCE BENEFICIARY

There is a change in our policy for designating your primary beneficiary. If you are married, you must designate at least 50 percent of your life insurance to your spouse. If you want to designate more than 50 percent of your life insurance to someone other than your spouse, your spouse must sign a beneficiary designation form, have it notarized, and deliver it to the Benefits Office in order for your designation to be valid. The beneficiary designation form is located online at http://ebc.maricopa.gov/hr/benefits and http://www.maricopa.gov/benefits.

THINGS TO CONSIDER IF YOU ARE CHANGING MEDICAL INSURANCE VENDORS

If you are considering changing health plans (CIGNA or HealthSelect), you will need to consider the following:

- ❖ You may need to select a new primary care physician (PCP).
  - If so, you will need to have your medical records from your PCP and any specialists for you and your family sent to your new PCP as soon as possible after January 1.
  - You may need to sign a medical release from your existing PCP or specialist in order to get your medical records released and sent to the new PCP.

- ❖ Make an appointment as soon as possible for shortly after January 1, 2004, to establish a relationship with your new PCP. Avoid waiting until there is a health crisis before making contact.
- ❖ Determine with your existing PCP if your supply of medication is sufficient until you are able to see your new PCP. If not, ask for a prescription with enough refills to get you through.
- ❖ Determine if your current medication is on the new provider's approved formulary list.
  - Switching to HealthSelect: Go to http://www.maricopa.gov/medcenter/healthplans/formulary.pdf to view the formulary or call Member Services at 602-344-8760.
  - Switching to any CIGNA plan: The formulary for the Walgreen's Health Initiatives Prescription Plan can be found at http:www.whphi.com or call WHI Customer Service toll-free at 800-207-2568.
  - Discuss with your current PCP possible alternatives to your current medication if your medication is not on the approved drug list (formulary). Make sure that your physician has documented all medications tried and failed in your medical record. This will be helpful and save time should there be questions regarding non-formulary medications you are using or should your medication require prior authorization.
- ❖ If you or a family member has a special need, you should contact HealthSelect's or CIGNA's member services departments for help in transitioning care. Special needs might include:
  - High-risk or third trimester pregnancies
  - Chronic illnesses such as diabetes, congestive heart failure
  - Mental illness
  - Chemotherapy and/or radiation therapy
  - Durable medical equipment, such as wheelchairs, walkers, oxygen equipment, etc.
  - Organ or tissue transplantation services in process
  - Home health services
  - Post surgical visits after the plan effective date
  - Scheduled elective surgeries
- ❖ Let your providers know you have changed insurance carriers and show your new ID card(s) to your new PCP, specialists, and pharmacy provider. New ID cards will arrive shortly before January 1.

BENEFITS OFFERED IN 2004

Many of your benefits will remain the same for 2004. A brief summary is provided below. For detailed information, Plan Documents, and the *Know Your Benefits* guide, please visit either the Intranet at http://ebc.maricopa.gov/hr/benefits or the Internet at http://www.maricopa.gov/benefits.

AUTO, HOME, AND RENTERS INSURANCE

You qualify for a special Maricopa County group discount on your auto, home, and renters insurance through Group Savings Plus from Liberty Mutual. Payroll deduction is available.

BEHAVIORAL HEALTH AND SUBSTANCE ABUSE SERVICES

Your behavioral health and substance abuse services continue to be provided by United Behavioral Health (UBH). There are no changes to this benefit.

CRITICAL ILLNESS COVERAGE

At your cost, you may purchase a supplemental critical illness insurance plan, underwritten by Trustmark Insurance Company, that pays a lump-sum amount upon the initial diagnosis of any covered critical illness. The plan is designed to cover indirect expenses associated with a critical illness such as loss of income, deductibles and copays, alternative treatments, meals and lodging, Out-of-Network treatments, home recovery, family care, and living expenses. There are no changes from 2003.

DEFERRED COMPENSATION

Your deferred compensation program is administered by Nationwide Retirement Solutions. This program lets you defer a portion of your earnings each pay period into an account for your retirement. When you contribute this portion of your income, you reduce the amount that is taxable. You're not only saving for tomorrow, you're postponing federal income taxes today. The maximum amount that you can defer is $13,000, or 100 percent of includible compensation, which ever is less. If you are age 50 or over, you may defer an additional $3,000 in 2004. The minimum amount of deferral is $20 per pay period. Please note the maximum deferral and catch-up amounts did change.

DENTAL PLAN CHOICES

Your dental benefits continue to be provided through either Employer's Dental Services (EDS), a pre-paid dental plan, or United Concordia, a Preferred Provider Organization (PPO) plan. There are no changes to United Concordia. There is a change to the orthodontic benefit for EDS. See the *What's New for 2004 Benefits* section above for details.

EMPLOYEE ASSISTANCE PLAN (EAP)

Your employee assistance plan benefit continues to be offered by ComPsych Guidance Resources. There have been no changes to this benefit.

LIFE INSURANCE

Your basic life, supplemental life, and accidental death and dismemberment insurance continues to be provided through UnumProvident. Medical underwriting may be required. Please note, the face value of life insurance and the premium for supplemental life is calculated on your base salary, regardless of any special work assignments. See the rates on page 18.

MARIFLEX FLEXIBLE SPENDING ACCOUNTS

Maricopa County offers a Flexible Spending Account that allows you to pay for health care and/or dependent care expenses with tax-free money. **This program requires you to enroll each benefit plan year.** You can use your Flexible Spending Account to pay for eligible uncovered health care expense such as office visit copayments, coinsurance, deductibles, and prescription copays/coinsurance. You can set aside up to $5,200 a year in a tax-free Health Care Flexible Spending Account. For dependent care, you can set aside up to $5,000 a year in a tax-free Dependent Care Flexible Spending Account.

On September 3, 2003, the IRS issued a Revenue Ruling that significantly changed the type of expenses that qualify for reimbursement from your health care flexible spending account (FSA). **Over-the-counter (OTC) drugs and medicines purchased to treat an existing or imminent medical condition now qualify as a covered medical expense through the FSA. This means items such as allergy medications, smoking cessation medications, aspirin, cold medications, vitamins*, and nutritional supplements* can be claimed if they are purchased to treat an existing or imminent medical condition. None of these items can be claimed if they are purchased for general health purposes or for possible future use.** *Annual documentation from your physician must be on file with ASI, the Mariflex administrator, to claim these items.

To review the complete Plan Document or to find out more about the OTC drug and medicine coverage, refer to the *Where to Access Benefits Information* section above.

MEDICAL PLANS

Your medical insurance continues to be provided by either HealthSelect or CIGNA. There are no changes to HealthSelect or CIGNA Health Maintenance Organization (HMO). There are some copayment and coinsurance changes with the CIGNA Point-of-Service (POS) and Preferred Provider Organization (PPO) products. See the *What's New for 2004 Benefits* section for details.

MEDICAL WAIVER

Maricopa County will compensate you $100 per month if you work at least 60 hours per pay period and WAIVE your medical coverage. You must be covered under other group health coverage and provide proof of your group health insurance coverage to qualify. If you choose to WAIVE your medical coverage online through the Open Enrollment System, you will need to enter your medical carrier name and ID number. This information is required and will be audited by the Benefits Office. Arizona Health Care Cost Containment System (AHCCCS) coverage does not qualify as group health insurance coverage and does not qualify you to waive your group medical benefits or to be eligible for the waiver payment.

PHARMACY BENEFIT FOR ALL CIGNA MEDICAL PLANS

Your pharmacy benefit continues to be administered by Walgreens Health Initiatives (WHI). There have been no changes to the pharmacy benefit. However, as a value-added benefit, you may now purchase excluded drugs, such as fertility and cosmetic medications, using the discounts provided to Maricopa County covered employees.

SHORT-TERM DISABILITY

Your short-term disability insurance continues to be provided through UnumProvident. Several plan design changes have been made to this benefit – rates have changed; and enrollment, dis-enrollment, and benefit level changes may only be made during Open Enrollment. There continues to be a pre-existing condition clause, which limits receipt of benefits for 12 months and applies to any changes in benefit level made during Open Enrollment. See the *What's New for 2004 Benefits* section for details. See the Plan Document for information regarding the pre-existing clause.

VISION BENEFIT

Your vision benefit for all CIGNA and HealthSelect medical plans continues to be provided through AVESIS Vision Plan. (If you select a CIGNA or HealthSelect product, you are automatically enrolled with AVESIS.) The cost of this benefit is included in your medical plan. The County is offering a separate vision plan for employees who choose to waive their medical benefits. See the *What's New for 2004 Benefits* section for details on the Medical Waiver and for information on enrolling in the separate vision plan.

MEDICAL PLAN CHOICES

HEALTHSELECT MEDICAL PLAN

A managed care plan sponsored by Maricopa County. All care is directed through a primary care physician (family practice, pediatrician, or internist) in either a private practice office setting or at a Family Health Center. Services may only be received within Maricopa County, except for emergency services. Referrals are required for all care except primary care, urgent care, emergency care, chiropractic care, and alternative medicine services. To see a list of practitioners participating in the HealthSelect network, pick up a provider directory at a Paper Depot or go to http://www.maricopa.gov/medcenter/healthplans/providerlist. To see the approved list of medications on the formulary, go to http://www.maricopa.gov/medcenter/healthplans/formulary.pdf or call Customer Service. Program features are listed below:

- $0 Deductible
- $5 Office Visit Copay
- $5 Specialist Visit Copay
- $5 Urgent Care Copay
- $50 Emergency Room Copay
- $0 Copay for Inpatient Hospitalization
- Prescription Drug Copay
  - $5 generic and $15 brand (Available if on approved HealthSelect formulary.)
- Prescription Mail Order Service
  - $15 generic and $30 brand copay, up to a 90-day supply (Available if on approved HealthSelect formulary.)
- $10 Chiropractic Copay – 12 visits per year, Chronic conditions are not covered, and care must be medically necessary.
- $0 Lab/X-ray/MRI Copay
- $0 Screening Exams Copay – Pap Smear, Prostate Screening, etc.
- Wellness Incentives
  - $75 Health Club incentive
  - $30 gift certificate from a variety store for Health Screenings, Children's Immunizations, Health Education classes, and Smoking Cessation classes
- $5 Alternative Medicine Copay – 6 visits per year, $60.00 credit for supplies and/or products; uses designated network
- $5 Physical, Speech, and Occupational Therapy Copay – 60 visits per year
- $125 Student Health Insurance Allowance per semester for full-time students up to 25 years old and residing outside Maricopa County
- Out-of-network coverage is NOT available

The HealthSelect Medical Plan includes behavioral health and substance abuse services provided by United Behavioral Health (UBH) and the pharmacy benefit is provided by HealthSelect.

CIGNA HEALTH MAINTENANCE ORGANIZATION (HMO)

A health maintenance organization in which all care is directed through a separate HMO network of primary care physicians (family practice, pediatrician, or internist) who deliver care at CIGNA Medical Group (CMG) facilities. You and each family member are required to select a Primary Care Physician. The HMO network also has a small hospital network. Referrals are required for all care except primary care, urgent care, emergency care, chiropractic care, and alternative medicine services. **Please Note**: Physicians in private practice offices are not included in this network! Services may only be received within Maricopa County, except for emergency assistance.

To see a list of practitioners and hospitals participating in the CIGNA HMO network, pick up a provider directory at a Paper Depot. Or go online at http://www.cigna.com, select the provider directory link from the home page, enter your physician search requirements, and select Your Benefit Plan or Program from the *For Network and Point of Service Plans* drop-down list box, select the AZ-CIGNA Medical Group option, and continue with the prompts. Program features are listed below:

- $0 Deductible
- $10 Office Visit Copay
- $10 Specialist Visit Copay
- $35 Urgent Care Copay
- $75 Emergency Room Copay
- $10 Chiropractic Copay – 20 visits per year*
- $10 Physical, Speech, and Occupational Therapy Copay – 60 visits per year*
- $50 MRI, MRA, PET, and CAT Scans Copay
- $0 Inpatient Hospitalization
- $0 Lab and X-ray Copay
- $5 Alternative Medicine Copay – 6 visits per year with a $60.00 credit for supplies and/or products; uses designated network
- Out of Pocket Maximum (applies to Inpatient and Outpatient Surgery copayments only)
  - Individual $1,000
  - Family $2,000
- Out-of network coverage is NOT available

*There is a 60 visit limit for therapies and chiropractic services In- and Out-of Network combined. Chronic conditions are not covered. Care must be medically necessary.

The CIGNA HMO Medical Plan includes behavioral health and substance abuse services provided by United Behavioral Health (UBH) and a three-level prescription drug benefit administered by Walgreens Health Initiatives (WHI).

CIGNA POINT OF SERVICE (POS)

A Point of Service Plan with In-Network and Out-of-Network benefits**. In-network** medical care is directed through a contracted primary care physician (family practice, pediatrician, or internist). Service is received in a physician's private practice office. Service may also be received in a CIGNA Medical Group facility if the primary care physician is contracted in both the private practice network and the CIGNA Medical Group network. Services must be received within the state of Arizona, except for emergency assistance. You and each family member are required to select a Primary Care Physician (PCP). Referrals are required from your PCP for all care except primary care, urgent care, emergency care, chiropractic care, and alternative medicine services. The POS network has a large hospital network. Only the Inpatient and Outpatient surgery copayments count towards the Out-of-Pocket Maximums.

Out-of-network medical care is received either without an In-Network primary care referral or through physicians, practitioners, or facilities that are not contracted with CIGNA. Not all services are available Out-of-Network. Benefits are subject to deductibles, except where a copayment applies. Benefits with a deductible must be satisfied before coinsurance amounts apply towards out of pocket maximums. The deductible does not apply to the out of pocket maximum.

Prior Authorization is required for certain services both In- and Out-of-Network.

To see a list of practitioners and hospitals participating in the CIGNA POS network, pick up a provider directory at a Paper Depot. Or go online at http://www.cigna.com, select the provider directory link from the home page, enter your physician search requirements, and select Your Benefit Plan or Program from the *For Network and Point of Service Plans* drop-down list box, select either AZ-Central and Northern for the Phoenix metro area or AZ-Southern Arizona for the Tucson area, and continue with the prompts. Program features are listed below:

IN-NETWORK

- $0 Deductible
- $15 Office Visit Copay
- $25 Specialist Visit Copay
- $50 Urgent Care Copay
- $100 Emergency Room Copay
- $15 Chiropractic Copay – 20 visits per year*
- $15 Physical, Speech, and Occupational Therapy Copay*
- $0 Lab and X-ray Copay
- $50 MRI, MRA, PET and CAT Scans Copay
- $100/day, $300 maximum per admission Inpatient Hospital Copay
- $100 Outpatient Surgery Copay
- $5 Alternative Medicine Copay – 6 visits per year, $60.00 credit for supplies and/or products; uses designated network
- Out-of-Pocket Maximums
  - Individual: $900
  - Family: $1,800

COVERED IN-NETWORK ONLY

- Durable Medical Equipment
- External Prosthetics/Orthotics
- Hearing/Vision Screening
- Infertility Diagnosis and Corrective Treatment
- Preventive Care
- Alternative Medicine
- Injections
- Chiropractic Care

OUT-OF-NETWORK

- Deductible:
  - Individual: $300
  - Family: $600
- Out-of-Pocket Maximums:
  - Individual: $3,000
  - Family: $6,000
- Lifetime Maximum: $5,000,000
- 12 Month Pre-Existing Condition Limitation
- 70% Standard Coinsurance: You pay 30% of reasonable and customary costs plus excess charge** after deductible
- Urgent Care Facility – 70% Standard Coinsurance after deductible
- $100 Emergency Room Copay
- $400 Pre-Certification Penalty***

* There is a 60-visit limit for therapies and chiropractic services In- and Out-of-Network combined. Chronic conditions are not covered. Care must be medically necessary.

** Excess charge is the difference between billed charges and reasonable and customary costs.

*** The approval a participating or non-participating provider must receive from the Healthplan Medical Director, prior to services being rendered, in order for certain services and supplies to be covered under the medical insurance agreement. If prior authorization is NOT approved, a penalty will be applied.

The CIGNA HMO Medical Plan includes behavioral health and substance abuse services provided by United Behavioral Health (UBH) and a three-level prescription drug benefit administered by Walgreens Health Initiatives (WHI).

CIGNA PREFERRED PROVIDER ORGANIZATION (PPO)

A Preferred Provider Organization Plan with In-Network and Out-of-Network benefits. **In-Network** medical care is accessed directly by the employee and/or family member through contracted physicians, practitioners, and/or facilities without referrals. The PPO network has the broadest selection of providers and hospitals. **Out-of-Network** medical care is accessed directly by the employee and/or family member through NON-CONTRACTED providers and/or facilities without referrals.

Prior Authorization is required for certain services both In- and Out-of-Network. Most benefits are subject to deductibles and coinsurance and coinsurance applies to the out-of-pocket maximum. Copayments are not counted towards the deductible. Not all services are available Out-of-Network. Services may be received anywhere that CIGNA's National Network operates.

To see a list of practitioners and hospitals participating in the CIGNA PPO network, pick up a provider directory at a Paper Depot. Or go online at http://www.cigna.com, select the provider directory link from the home page, enter your physician search requirements, and select Your Benefit Plan or Program for Preferred Provider Organizations (PPO), and continue with the prompts. You are not required to select a Primary Care Physician (PCP) and you can go to any participating PPO provider you chose, even a specialist. Program features are listed below:

IN-NETWORK

- 12 Month Pre-Existing Condition Limitation
- Deductible
  - Individual: $250
  - Family: $500
- Out-of-Pocket Maximums
  - Individual: $2,000
  - Family: $6,000
- 80% Standard Coinsurance – You pay 20% of the contracted rate after annual deductible for:
  - Office Visits
  - Specialist Visits
  - Lab and X-ray
  - Maternity Care Office Visit Coinsurance – for the first visit, then it's covered 100%.
  - Inpatient Hospitalization
  - Chiropractic Care (Unlimited visits. Chronic conditions are not covered. Care must be medically necessary.)
  - Physical, Speech, and Occupational Therapy (There is a 60 visit limit for therapies In- and Out-of-Network combined. Chronic conditions are not covered. Care must be medically necessary.)
- $5 Alternative Medicine Copay – 6 visits per year, $60.00 credit for supplies and/or products; uses designated network.
- $50 Urgent Care Copay – deductible does not apply
- $100 Emergency Room Copay – deductible does not apply
- $400 Prior Authorization Penalty**

COVERED IN-NETWORK ONLY

- Hearing/Vision Screening
- Infertility Diagnosis and Corrective Treatment
- Preventive Care
- Alternative Medicine

OUT-OF-NETWORK

- 12 Month Pre-Existing Condition Limitation
- Deductible
  - Individual: $750
  - Family: $1,500
- Out-of-Pocket Maximums
  - Individual: $4,000
  - Family: $12,000
- Lifetime Maximum: $5,000,000
- 60 percent Standard Coinsurance – You Pay 40 percent of the reasonable and customary costs plus excess charge* after deductible for:
  - Office Visits
  - Specialist Visits
  - Inpatient Hospitalizations
  - Chiropractic Care (Unlimited visits. Chronic conditions are not covered. Care must be medically necessary.)
  - Physical, Speech, and Occupational Therapy (There is a 60 visit limit for therapies In- and Out-of-Network combined. Chronic conditions are not covered. Care must be medically necessary.)
  - Urgent Care Facility visit
- $100 Emergency Room Copay
- $400 Prior Authorization Penalty**

* Excess charge – the difference between billed charges and reasonable and customary costs.

** The approval a participating or non-participating provider must receive from the Healthplan Medical Director, prior to services being rendered, in order for certain services and supplies to be covered under the medical insurance agreement. If prior authorization is NOT approved, a penalty will be applied.

The CIGNA PPO Medical Plan includes behavioral health and substance abuse services provided by United Behavioral Health (UBH) and a three-level prescription drug benefit administered by Walgreens Health Initiatives (WHI). Some benefits are subject to deductibles and out-of-pocket maximums.

PHARMACY BENEFIT FOR CIGNA MEDICAL PLANS

WALGREENS HEALTH INITIATIVES (WHI)

ALL CIGNA medical products have one pharmacy benefit that is administered through Walgreens Health Initiatives (WHI). If you select CIGNA HMO, you will fill your prescriptions through Walgreens Health Initiatives Network and NOT through the pharmacies located in the CIGNA Medical Group facilities operated by CIGNA. Convenient WHI pharmacy locations include Albertson's, Basha's, CVS, Eckerd's, Fry's, K-Mart, Osco, Safeway, Sam's Club, Target, Walgreens, and Wal-Mart. Many pharmacies have extended hours.

The pharmacy benefit is a three-level plan that includes the following:

- Generic Prescriptions - You are responsible for 25% of the contracted cost.* The cost for each prescription will not be less than $2.00 or more than $10.00.
- Brand name prescriptions ON the approved list - You are responsible for 30% of the contracted cost.* The cost for each prescription will not be less than $5.00 or more than $25.00.
- Brand name prescriptions OFF the approved list - You are responsible for 30% of the contracted cost.* The cost for each prescription will not be less than $20.00 or more than $50.00.

*Contracted Cost - Discounted Average Wholesale Price of the Prescription plus the dispensing fee.

For each prescription that is filled, you and your physician, can select from a generic, brand on, or brand off medication. Some drugs require prior authorization. Quantity limits apply to certain medications. Some drugs classes are excluded.

Other features available through WHI include a mail order service and a 90-day retail program for maintenance medications.

Your pharmacy benefit offers financial protection. An individual will never pay more than $1,500 per year, and a family will never pay more than $3,000 per year for covered prescription medications. Once the annual maximum is met, all other covered prescriptions for the remainder of the year will be available at no cost to the individual and/or their family.

The formulary for the Walgreen's Health Initiatives Prescription Plan can be found at http:www.whphi.com or call WHI Customer Service toll-free at 1-800-207-2568.

To review the complete Plan Document, refer to the *Where to Access Benefits Information* section.

BEHAVIORAL HEALTH AND SUBSTANCE ABUSE SERVICES

UNITED BEHAVIORAL HEALTH (UBH)

There is no deductible for this benefit. Benefits are payable only if services are pre-authorized by UBH before you start treatment and services have been determined to be medically necessary, except for Out-of-Network outpatient services. Program features are listed below:

IN-NETWORK

- $25 per day inpatient hospital copay
- $100 per program intensive outpatient copay
- $10 per visit outpatient individual therapy copay
- $5 per visit outpatient group therapy copay
- $12.50 per day residential treatment copay
- Limits
  - 30 inpatient days per year
  - 60 residential days per year
  - 30 individual therapy outpatient visits for In- and Out-of-Network combined
  - 60 group therapy outpatient visits for In- and Out-of-Network combined
  - Unlimited mental health/substance abuse lifetime maximum

OUT-OF-NETWORK

- $25 benefit per visit outpatient individual therapy – you pay the balance of the bill
- $25 benefit per visit outpatient group therapy – you pay the balance of the bill
- Limits
  - 30 individual therapy outpatient visits for In- and Out-of-Network combined
  - 60 group therapy outpatient visits for In- and Out-of-Network combined
  - $5,000,000 mental health/substance abuse lifetime maximum

If your medical provider is CIGNA, your three-level prescription drug benefit is administered through Walgreens Health Initiatives (WHI). If your medical provider is HealthSelect, your prescription drug benefit is administered through HealthSelect.

DENTAL PLANS

Maricopa County employees may purchase dental insurance from one of two dental vendors – United Concordia or Employers Dental Service (EDS). Dental coverage may be purchased even if you waive medical insurance coverage.

UNITED CONCORDIA DENTAL

United Concordia Dental offers you freedom of choice in selecting your dental provider by offering a product with In-Network benefits as well as Out-of-Network benefits.

If your dentist participates in United Concordia's network, the dentist will submit your claim, receive direct payment from United Concordia, and accept the fee paid as payment in full (after your deductible and/or copayment).

If you use a non-participating, Out-of-Network dentist, you can assign payments to that dentist by signing the claim form appropriately. If you do this, your dentist will likely submit the claim for you since the dentist will be paid directly by United Concordia Dental. If the dentist will not bill United Concordia directly, you will be responsible for submitting the claim.

United Concordia compensates all dentists according to its maximum allowable charge (MAC) schedules. Participating dentists agree to accept these allowances as payment in full, for covered services less applicable copayments, coinsurance and deductibles. Non-participating providers are under no obligation to accept the payment as full payment, and may bill you for the difference between the billed charges and United Concordia's MAC schedule.

To see a list of practitioners participating in the United Concordia network, pick up a provider directory at a Paper Depot or go online at http://www.ucci.com. To review the complete Plan Document, refer to the *Where to Access Benefits Information* section. Program features are listed below.

EMPLOYERS DENTAL SERVICES (EDS)

Employer's Dental Service (EDS) is a prepaid dental care organization. The advantages of joining a prepaid dental plan include no deductible, no claim forms, no yearly maximums, orthodontic services for children and adults, a prescription discount program, a large network of participating dentists, emergency benefit 24 hours a day, value and affordability with a focus on preventive procedures.

Specialty care is provided at a discount. A discount for the treatment of TMJ is also part of your dental care benefit. A referral is not required to see a EDS Specialist.

Immediate coverage is available for basic, preventive and major services. EDS covers pre-existing conditions, except for procedures in progress at time of enrollment. As an EDS member, you choose a General dentist from the network of contracted (participating) dentists. All members of your family choose the same dentist. You have the freedom to change dentists, with all changes received by the 20th of the month becoming effective the first of the following month.

To see a list of practitioners participating in the EDS network, pick up a provider directory at a Paper Depot or go online at http://www.mydentalplan.net.

To review the complete Plan Document, refer to the *Where to Access Benefits Information* section above. Program features are listed below.

The information and benefits described herein are brief summaries of the County's official plan documents and contracts that govern the plans. If there is a discrepancy between the information in this booklet and the official documents, the official documents will govern. All references to year refer to a calendar year unless otherwise specified.

DENTAL PLANS COMPARED

Features	United Concordia	Employers Dental Services
Annual Calendar Year Maximum per person	$2,000	None
Orthodontic Service	Diagnostic, active and retention treatment 50% coinsurance Adults and dependent students through age 24 $1,500 Lifetime Orthodontic Maximum; lifetime maximum will be coordinated with prior group insurance carrier; continuing services previously covered under a pre-paid dental plan will not be covered.	Choose one of two plans **Madera Plan** Up to two years active banding: Under age 19 copayment of $2,475 - $3,345 copayment Over age 19 copayment of $2,675 - $3,595 copayment Not all procedures or treatments are covered; some limitations and exclusions apply OR **25% discount on all orthodontic services** Metal banding, invisible braces, and Invisalign braces are covered Appliances such as expanders, reverse headgear, Herbst, Pendulum, Nance, Tongue Crib, Jaspers, Sagittal, and Schwartz Prices on which the discount is calculated may vary by orthodontist
Provider Network Access	In-Network (participating) and Out-of-Network, (non-participating) providers both available	Must use EDS contracted dentists
Deductible	$50 per person/$100 per family (waived for diagnostic, preventive and orthodontic services)	None
Diagnostic and Preventive Services	100% coverage for Diagnostic, Preventive, and Palliative Services Routine Oral Exams/ cleanings (twice/year) X-rays (limits apply) Sealants of permanent molars (through age 15) Fluoride (twice per year through age 18)	Diagnostic and Preventive Services(at general dentist): Office visit/$3 Routine Oral Exam - $0 Cleaning - $0 Oral exam - $0 X-rays - $0 Sealants -$12 per tooth Fluoride - $0 Emergency Services - up to $200 reimbursement less applicable copayment(s)
Basic Restoration Services	Basic Services 80% coverage Fillings (amalgam on posterior teeth) Oral Surgery Endodontics Periodontics Repair of denture and bridgework Simple extractions Complex Oral Surgery General Anesthesia	Basic Services (at general dentist): Fillings (amalgam) $8 - $21 copayment Fillings (resin) $22 - $40 copayment Oral Surgery: from $35 copayment Endodontics: root canal $170 - $265 copayment Periodontics: debridement $80 copayment; Scaling and root planing/quadrant $90 copayment
Major Services	Major Restorative 50% coverage Inlays, Onlays, Crowns Partial or complete dentures Fixed bridges	Major Restorative(at general dentist): Crown porcelain w/metal $250 copayment + lab fee Complete dentures upper or lower $325 copayment for each + lab fee Partial dentures upper or lower (resin base) $375 copayment for each + lab fee Bridge per pontic $250 copayment + lab fee

TECHNICAL SUPPORT QUESTIONS

If you are having technical difficulties using the online open enrollment system call the eGov Help Desk at 602-506-4357, Monday – Friday, 6:30 AM – 5:00 PM.

OPEN ENROLLMENT ONLINE INSTRUCTIONS

Call the Help Desk at 602-506-HELP (4357), Monday – Friday, 6:30 AM – 5:00 PM, if you have technical support questions or problems using the Open Enrollment system. Your computer must have Internet Explorer version 5.5 SP2 installed, cookies must be enabled, and JavaScript must be enabled in order to access the online Open Enrollment system.

OPEN ENROLLMENT ON THE INTERNET

1. Start your browser
2. At the URL Address line, type **https://www.maricopa.gov/openenrollment**, then press <Enter>. Please note the "**s**" in https. This lets you know you are on a secured web site.
3. Be sure to fully complete the enrollment process within 20 minutes since this web site will time out. **If the site times out, your changes will not be saved, and you will have to start the entire process from the beginning.**
4. You will see a screen that explains the site is restricted to authorized personnel and asks for an Open Enrollment PASSWORD.
5. Type in **PFU2RNG4A**, which must be in all CAPITAL LETTERS, then click on the <Continue> button.
6. You will see the Open Enrollment Welcome screen. Follow the instructions to start the enrollment process.
7. Logon by using either your Social Security Number or your Employee ID Number. Your Employee ID Number can be found on your paycheck stub.
8. Click the tabs at the top of the screen to move from screen to screen.
9. Review the information on each screen and make any changes you desire.
10. Some screens require you to use the scroll bar to scroll down to the bottom of the screen.
11. To add a new dependent, use the appropriate button on the bottom of the Dependents screen. To delete a dependent, use the delete box on the left-hand side of the screen. To correct information about a dependent, use the edit box on the left-hand side of the screen. Beneficiary information can be added, changed, or deleted using the same process on the Life screen.
12. When you are done, click the "Finish" tab to review your selections. You must click on the Confirm button at the bottom of this screen.
13. A new screen will appear asking you to Please Read the Following. Check the box authorizing deductions, review the email address listed or enter an email address, if available, for which to receive you benefit confirmation statement, and then click the Finish button at the bottom of the screen to complete Open Enrollment.
14. When you see a message stating, "Your 2004 Benefit Selections were Updated Successfully!" you have completed the open enrollment process.
15. Print this screen as proof of your Open Enrollment elections and keep it for your records.
16. You may go into the Open Enrollment system and make changes as often as needed during the Open Enrollment dates. Your latest completed enrollment changes will take effect January 1, 2004.

OPEN ENROLLMENT ON THE EBC/INTRANET

1. Start your browser.
2. If your home page is not set to the EBC main page, type in **http://ebc.maricopa.gov** and press <Enter>.
3. Be sure to fully complete the enrollment process within 20 minutes since this web site will time out. **If the site times out, your changes will not be saved, and you will have to start the entire process from the beginning.**
4. You will see the Open Enrollment Welcome screen. Follow the instructions to start the enrollment process.
5. Logon by using either your Social Security Number or your Employee ID Number. Your Employee ID Number can be found on your paycheck stub.
6. Click the tabs at the top of the screen to move from screen to screen.
7. Review the information on each screen and make any changes you desire.
8. Some screens require you to use the scroll bar to scroll down to the bottom of the screen.
9. To add a new dependent, use the appropriate button on the bottom of the Dependents screen. To delete a dependent, use the delete box on the left-hand side of the screen. To correct information about a dependent, use the edit box on the left-hand side of the screen. Beneficiary information can be added, changed, or deleted using the same process on the Life screen.
10. When you are done, click the "Finish" tab to review your selections. You must click on the Confirm button at the bottom of this screen.
11. A new screen will appear asking you to Please Read the Following. Check the box authorizing deductions, review the email address listed or enter an email address, if available, for which to receive you benefit confirmation statement, and then click the Finish button at the bottom of the screen to complete Open Enrollment.
12. When you see a message stating, "Your 2004 Benefit Selections were Updated Successfully!" you have completed the open enrollment process.
13. Print this screen as proof of your Open Enrollment elections and keep it for your records.
14. You may go into the Open Enrollment system and make changes as often as needed during the Open Enrollment dates. Your latest completed enrollment changes will take effect January 1, 2004.

If you are on an Intranet site other than the Electronic Business Center (EBC), you can use the Internet instructions above from any computer with Internet access to complete your Open Enrollment online.

2004 OPEN ENROLLMENT VENDOR FAIR SCHEDULE

The Benefits Office is hosting vendor fairs at the following locations between the times listed Please plan to visit a fair to receive vendor information or to have your specific benefit questions answered by the vendors. Not all vendors will have provider directories available. Please visit the vendor's web sites or the Benefit Office's web sites for information online. If you don't have access to a computer, please visit a Paper Depot.

DATE	LOCATION	ADDRESS	TIME
Tuesday 10/14/2003	Maricopa County Administration Building Breezeway – 2nd floor	301 W. Jefferson St Phoenix, AZ 85003	11:00 AM – 1:00 PM
Tuesday 10/14/2003	Environmental Services Cavco Bldg., Suite 560	1001 N. Central Ave Phoenix, AZ 85004	2:30 PM – 4:30 PM
Wednesday 10/15/2003	Maricopa Managed Care Held outside	2444 E. University Ave Phoenix, AZ 85034	11:00 AM – 1:00 PM
Thursday 10/16/2003	Maricopa Medical Center Auditorium 3 & 4	2601 E. Roosevelt Phoenix, AZ 85008	7:00 AM – 9:00 AM
Thursday 10/16/2003	Southeast Regional Library Training Rooms	775 N. Greenfield Road Gilbert, AZ 85234	12:00 AM – 2:00 PM
Tuesday 10/21/2003	Flood Control Adobe/Harq Conference Rooms	2801 W. Durango Ave Phoenix, AZ 85009	2:30 PM – 4:30 PM
Wednesday 10/22/2003	Maricopa County Administration Building Breezeway – 2nd floor	301 W. Jefferson St Phoenix, AZ 85003	7:00 AM – 9:00 AM
Wednesday 10/22/2003	Maricopa Medical Center Auditorium 1	2601 E. Roosevelt Phoenix, AZ 85008	2:00 PM – 4:00 PM
Thursday 10/23/2003	Maricopa Managed Care Held outside	2444 E. University Ave Phoenix, AZ 85034	11:00 AM – 1:00 PM
Thursday 10/23/2003	Juvenile Court Center Southeast Facility, Employee Lounge	1810 S. Lewis Mesa, AZ 85210	2:30 PM – 5:00 PM
Tuesday 10/28/2003	Dept of Transportation Apache/Cochise Conference Rm.	2901 W. Durango Phoenix, AZ 85009	6:00 AM – 9:00 AM
Wednesday 10/29/2003	Maricopa Medical Center Apache Room	2601 E. Roosevelt Phoenix, AZ 85008	7:00 AM – 9:00 AM
Wednesday 10/29/2003	Juvenile Probation Room 223	3125 W. Durango Ave Phoenix, AZ 85009	1:30 PM – 4:00 PM
Thursday 10/30/2003	Maricopa County Administration Building Breezeway – 2nd floor	301 W. Jefferson Street Phoenix, AZ 85003	3:00 PM – 5:00 PM

ADDITIONAL OPEN ENROLLMENT INFORMATION

PAPER DEPOTS

If you are not able to access the Open Enrollment information by computer, you can pick up enrollment material such as enrollment forms and provider directories and plan overviews at the following Paper Depot locations. Please help us keep waste and data entry time to a minimum by using paper **ONLY** if you cannot access the online system. Benefit information may be accessed online through the Internet at http://www.maricopa.gov/benefits or Intranet at http://ebc.maricopa.gov/hr/benefits.

Superior Court Law Library
101 W. Jefferson, 3rd Floor
Phoenix

Employee Benefits Office, County Administration Building
301 W. Jefferson, Suite 201
Phoenix

Juvenile Court Center
3125 W. Durango
Phoenix

South East Facility, Juvenile Court Center Executive Offices
1810 S. Lewis, 2nd Floor
Mesa

Maricopa Managed Care
2502 E. University, Suite 125
Phoenix

Maricopa Medical Center, Education Building
2601 E. Roosevelt
Phoenix

2004 PREMIUM COSTS

Important Reminder: Payroll deductions for the insurance plans will be made from the first two pay checks of the month, 24 pay checks per year instead of 26, beginning in 2004. Only the Mariflex flexible spending accounts will continue to be deducted from all 26 pay checks. Actual premium deduction may vary by one or two cents due to rounding.

HEALTHSELECT MEDICAL PLAN

Premium includes coverage for Medical, Pharmacy, Behavioral Health and Substance Abuse, and Vision. Medical and pharmacy coverage is provided by HealthSelect. Behavioral health and substance abuse coverage is provided by United Behavioral Health. Vision coverage is provided by Avesis.

	FULL-TIME		***PART-TIME***	
	60 hours or more per pay period		Between 40 - 59 hours per pay period	
	County Contribution Per Payday	Employee Cost Per Payday	County Contribution Per Payday	Employee Cost Per Payday
Employee	$133.27	***$0.00***	$133.27	***$0.00***
Employee and Spouse	$238.08	***$15.84***	$238.08	***$15.84***
Employee and Child(ren)	$199.67	***$12.16***	$199.67	***$12.16***
Employee and Family	$287.32	***$36.16***	$287.32	***$36.16***

ALL CIGNA PLAN PREMIUMS INCLUDE:

Coverage for Medical, Pharmacy, Behavioral Health and Substance Abuse services, and Vision. The medical coverage is provided by CIGNA. The pharmacy coverage is administered by Walgreens Health Initiatives (WHI). The behavioral health and substance abuse coverage is provided by United Behavioral Health (UBH). The vision coverage is provided by Avesis.

CIGNA HMO (HEALTH MAINTENANCE ORGANIZATION)

	FULL-TIME		***PART-TIME***	
	60 hours or more per pay period		Between 40 – 59 hours per pay period	
	County Contribution Per Payday	Employee Cost Per Payday	County Contribution Per Payday	Employee Cost Per Payday
Employee	$163.42	***$2.97***	$87.81	***$78.59***
Employee and Spouse	$301.01	***$29.47***	$247.27	***$83.21***
Employee and Child(ren)	$253.44	***$20.38***	$192.19	***$81.63***
Employee and Family	$391.48	***$46.99***	$352.18	***$86.30***

CIGNA POS (POINT OF SERVICE)

	FULL-TIME		***PART-TIME***	
	60 hours or more per pay period		Between 40 – 59 hours per pay period	
	County Contribution Per Payday	Employee Cost Per Payday	County Contribution Per Payday	Employee Cost Per Payday
Employee	$163.42	***$10.32***	$87.81	***$85.93***
Employee and Spouse	$301.01	***$44.20***	$247.27	***$97.94***
Employee and Child(ren)	$253.44	***$32.54***	$192.19	***$93.79***
Employee and Family	$391.48	***$66.53***	$352.18	***$105.83***

CIGNA PPO (PREFERRED PROVIDER ORGANIZATION)

	FULL-TIME		***PART-TIME***	
	60 hours or more per pay period		Between 40 – 59 hours per pay period	
	County Contribution Per Payday	Employee Cost Per Payday	County Contribution Per Payday	Employee Cost Per Payday
Employee	$161.72	***$46.64***	$86.11	***$122.26***
Employee and Spouse	$299.31	***$116.82***	$245.57	***$170.56***
Employee and Child(ren)	$251.74	***$92.46***	$190.49	***$153.71***
Employee and Family	$389.78	***$162.74***	$350.48	***$202.05***

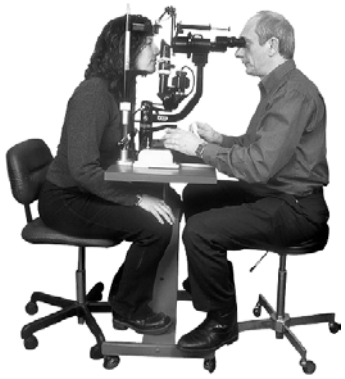
DENTAL PLANS

Employee Choices:	**Employer Dental Services (EDS)**		**United Concordia**	
	Pre-Paid Dental		***PPO Dental***	
	County Contribution Per Payday	Employee Cost Per Payday	County Contribution Per Payday	Employee Cost Per Payday
Employee	$2.47	***$1.86***	$8.29	***$6.25***
Employee and Spouse	$4.72	***$3.56***	$18.28	***$13.79***
Employee and Child(ren)	$6.09	***$4.59***	$19.76	***$14.91***
Employee and Family	$7.13	***$5.38***	$25.40	***$19.17***

AVESIS VISION OPTION WITH MEDICAL WAIVER

100 percent Paid by Employee

	Employee Cost Per Payday
Employee	***$3.42***
Employee and Spouse	***$6.46***
Employee and Child(ren)	***$7.04***
Employee and Family	***$9.06***



SHORT-TERM DISABILITY PLAN

100 percent Paid by Employee

Short-Term Disability Options	**Rate Multiplier for 24 Pay Periods**
40% of Biweekly Base Salary* ($2,000 bi-weekly maximum benefit)	$0.0035
50% of Biweekly Base Salary* ($2,000 bi-weekly maximum benefit)	$0.0050
60% of Biweekly Base Salary* ($2,000 bi-weekly maximum benefit)	$0.0065
70% of Biweekly Base Salary* ($2,000 bi-weekly maximum benefit)	$0.0080

SHORT-TERM DISABILITY EXAMPLE

Annual Salary: **$25,000**	**40% Premium**	**50% Premium**	**60% Premium**	**70% Premium**
Multiply Annual Base Salary by Rate Multiplier to determine annual premium	$25,000 X 0.0035	$25,000 X 0.0050	$25,000 X 0.0065	$25,000 X 0.0080
Annual Premium	**$87.50**	**$125.00**	**$162.50**	**$200.00**
Divide Annual Premium by 24 pay periods to determine payroll deduction	$87.50 ÷ 24	$125.00 ÷ 24	$162.50 ÷ 24	$200.00 ÷ 24
Payroll Deduction for 24 pay periods **ONLY**	**$3.65**	**$5.21**	**$6.77**	**$8.33**

*Up to maximum benefit coverage

LIFE INSURANCE

BASIC LIFE WITH ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

1 Times Base Salary – Paid by Maricopa County

SUPPLEMENTAL LIFE INSURANCE WITH ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

1 to 5 Times Base Salary – Paid by Employee

SUPPLEMENTAL LIFE INSURANCE TABLE

5 Year Age Categories	Employee Cost per Payday Per $1,000 of Coverage	Employee Cost per Payday Per $1,000 of Coverage
	Smoker Multiplier	***Non-Smoker Multiplier***
Under 25	$0.0475	$0.0340
25-29	$0.0500	$0.0380
30-34	$0.0540	$0.0460
35-39	$0.0855	$0.0500
40-44	$0.1170	$0.0620
45-49	$0.2195	$0.1015
50-54	$0.3935	$0.1765
55-59	$0.4005	$0.2240
60-64	$0.6125	$0.3725
65-69	$0.7475	$0.5225
70 and older	$1.2175	$0.9575

SUPPLEMENTAL LIFE INSURANCE EXAMPLE

1. Take your annual base salary – **Example: $24,500**					
2. Round **up** to the nearest $1,000 and then multiply	1 X Salary	2 X Salary	3 X Salary	4 X Salary	5 X Salary
	$25,000	$50,000	$75,000	$100,000	$125,000
3. Take the Salary amount and divide by $1,000	25	50	75	100	125
4. Refer to the Supplemental Life Insurance table above to find your age category and cost multiplier					
5. Multiply the results from the calculation in Step 3 by the multiplier.					

Example: Age 37	***Multiplier for Smoking***	***Multiplier for Non-Smoking***	***Coverage Amount***
	$0.085500	***$0.050000***	
1 X Salary	$0.0855 X 25 = $2.14	$0.0500 X 25 = $1.25	$25,000
2 X Salary	$0.0855 X 50 = $4.28	$0.0500 X 50 = $2.50	$50,000
3 X Salary	$0.0855 X 75 = $6.41	$0.0500 X 75 = $3.75	$75,000
4 X Salary	$0.0855 X 100 = $8.55	$0.0500 X 100 = $5.00	$100,000
5 X Salary	$0.0855 X 125 = $10.69	$0.0500 X 125 = $6.25	$125,000

DEPENDENT LIFE INSURANCE

100 percent Paid by Employee

	Option One	Option Two
Spouse	$5,000	$10,000
Children, live birth to 14 days	$1,000	$1,000
14 days to 19 years, 25 years if full-time student	$2,500	$5,000
Employee Cost Per Payday:	***$0.83***	***$1.67***

You must have a qualified status change as defined by the Internal Revenue Code under Section 125 in order to change your medical, dental, or reimbursement accounts after initial enrollment or following the closing date of the Open Enrollment period for 2004. Please refer *to When Can Changes be Made?* and *What is a Qualified Status Change?* sections in the *Know Your Benefits* guide for details.

The information and benefits described herein are brief summaries of the County's official plan documents and contracts that govern the plans. If there is a discrepancy between the information in this booklet and the official documents, the official documents will govern. All references to year refer to a calendar year unless otherwise specified.

GLOSSARY OF MANAGED CARE TERMS

Coinsurance: A cost-sharing requirement under a health insurance policy, which provides that the insured will assume a portion or percentage of the costs of covered services after payment of the deductible.

Copayment : A cost-sharing arrangement in which the insured pays a specified flat dollar amount for a specific service (such as $15 for an office visit). The amount does not vary with the cost of the service, unlike co-insurance, which is based on some percentage of cost.

Deductible(s): Amounts required to be paid by the insured under a health insurance contract, before benefits become payable.

Flexible Spending Account (FSA): A plan which provides employees with a way to set aside money on a pre-taxed basis to cover the costs of either health care expenses that are not covered under their medical insurance coverage (medical, dental and vision), or dependent care expenses that enable the employee to work.

Formulary: Varying list of prescription drugs approved by a health plan or a pharmacy benefit manager for distribution to an insured through specific pharmacies.

Health Maintenance Organization (HMO): HMOs offer comprehensive health coverage for both hospital and physician services. An HMO contracts with health care providers, e.g., physicians, hospitals, and other health professionals who participate in their network. The members of an HMO are required to use participating network providers for all health services and many services need to meet further approval by the HMO through its utilization program. HMOs are the most restrictive form of managed care benefit plans because they restrict the procedures, providers, and benefits.

Healthplan Medical Director: A physician charged by the Healthplan to assist in managing the quality of the medical care provided by participating providers in the Healthplan's network.

Insured: A person or organization covered by an insurance policy.

Insurer (Insurance Company): A corporation, such as CIGNA HealthCare of Arizona, engaged primarily in the business of furnishing insurance to the public.

Medical Waiver Payment: Compensation paid to the employee by the County if medical coverage is not elected because of enrollment in other group health insurance. Waiving medical coverage means waiving coverage for all components of the medical plan, which includes medical, vision, prescription, behavioral health and substance abuse benefits.

PCP (Primary Care Physician): A physician who practices general medicine, family medicine, internal medicine or pediatrics who, through an agreement with the insurer, participates in the network, provides basic health care services and arranges specialized services, if chosen as the insured's primary care physician (PCP).

Point-of-Service Plan (POS): A point of service plan gives options each time the participant needs medical care. Providers and coverage level may be chosen at the time of service. When the insured's Primary Care Physician (PCP) coordinates medical care, only a copayment for office visits is charged. Out-of-pocket costs for hospital and outpatient care are lowest. Authorization is necessary for hospitalizations and some types of outpatient care. There are no claims to file. The PCP handles everything. When care is received from a provider who is not in the insurer's network or care is received without getting a referral from the PCP, out-of-pocket costs will be higher, and some services may not be covered. Authorizations and filing of claims become the responsibility of the insured. An annual deductible must be met and then covered services are covered only up to the plan's reasonable and customary amounts. Coverage of pre-existing conditions may be limited.

Preferred Provider Organization (PPO): A preferred provider organization is a plan that allows the insured to access medical services directly without coordinating care through a primary care physician (PCP). The plan offers a broad national network of providers. When care is received by a provider who is participating in the insurer's network, out-of-pocket expenses are lower. When care is received by a non-participating provider, costs are higher. Not all services are available outside the network. Coverage of pre-existing conditions may be limited.

Short-Term Disability (STD) Benefits: Short-term disability (STD) pays a percentage of the insured's salary if he/she becomes temporarily disabled due to sickness or injury and is not able to perform the essential functions of the job. The insured must be under the regular care and treatment of a licensed physician. A STD policy provides a weekly portion of the insured's salary for up to 26 weeks.

Who to Contact

Effective January 1, 2004

EMPLOYEE BENEFITS	PHONE	E-MAIL	WEB ADDRESS
Maricopa County Benefits Office Maricopa County Administration Building 301 West Jefferson Street, Suite 201 Phoenix, Arizona 85003-2145	602-506-1010 Fax 602-506-2354	BenefitsService@ mail.maricopa.gov	**Internet**: www.maricopa.gov/benefits **Intranet**: ebc.maricopa.gov/hr/benefits
MEDICAL PLANS			
CIGNA (HMO and POS)	800-244-6224		www.cigna.com
CIGNA (PPO)	800-251-0669		www.mycigna.com
HealthSelect Outside Phoenix	602-344-8760 800-582-8686		www.maricopa.gov/medcenter/healthplans
PHARMACY PLANS			
Walgreens Health Initiatives (WHI) (For ALL CIGNA Medical Plans)	800-207-2568 (Member Services)		www.whphi.com
WHI Clinical Prior Authorization	877-665-6609		
Walgreens HealthCare Plus' Mail Order Member Service	888-265-1953		
Mail Order Refills	800-797-3345		
HealthSelect Outside Phoenix	602-344-8760 800-582-8686		www.maricopa.gov/medcenter/healthplans
BEHAVIORAL HEALTH PLAN			
United Behavioral Health Included in HealthSelect and all CIGNA Medical plans	866-312-3078		www.ubhnet.com
VISION PLAN			
AVESIS (Included in HealthSelect and all CIGNA medical plans)	800-828-9341	info@avesis.com	www.avesis.com
DENTAL PLANS			
United Concordia	800-332-0366		www.ucci.com
Employer's Dental Service (EDS)	602-248-8912 800-722-9772		www.mydentalplan.net
UNUM LIFE INSURANCE AND SHORT-TERM DISABILITY			
Short-Term Disability	800-345-6495		
Life Customer Service	800-421-0344		www.unum.com
OTHER IMPORTANT NUMBERS			
ASI: Mariflex Administrator	800-659-3035	asi@asiflex.com	www.asiflex.com
Nationwide Retirement Solutions: Deferred Compensation	602-266-2733 800-653-4632	askus@nationwide.com	nationaldeferred.nrsservicecenter.com/nrs
Liberty Mutual: Auto, Home, and Renters Insurance	800-221-8135		www.libertymutual.com/lm/maricopafcu
Trustmark: Critical Illness Coverage	480-991-4444, ext. 15	enrollment@einsteinbenefit.com	
ComPsych Guidance Resources: EAP	888-355-5385 to speak with a counselor 877-595-5289 for web site technical support **ONLY**		www.guidanceresources.com
Arizona State Retirement System Outside of Phoenix	602-240-2000 800-621-3778		www.asrs.state.az.us
Public Safety Retirement System	602-255-5575		www.psprs.com
ERISA: COBRA Administrator	602-234-0593	erisaaz@aol.com	